

06867

6878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>B.</b> Last <b>Arthur</b>				4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1897</b>	
9. AGE (In years last birthday) yrs. <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b>		11. BIRTHPLACE (State or foreign country) <b>Little Creek, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John T. Buckson</b>				14. MOTHER'S MAIDEN NAME <b>Laura M. Montgomery</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the right face</b> <b>191X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>6/19/57</b> , 19____, to <b>6/27/57</b> , 19____, that I last saw the deceased alive on <b>6/27/57</b> , 19____, and that death occurred at <b>2:50 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. <b>Deer's Head State Hospital</b> <b>6/27/57</b> PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>June 29-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Glenn F. Seitz</b>				ADDRESS <b>5209 York Rd Baltimore Md</b>		24a. REC'D BY REGISTRAR <b>1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

JUL 2 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06868

6879

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>307 New York Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>ADMIRAL TAW AYERS</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>June 2nd 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>December 10, 1884</b>	9. AGE last birthday <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>22</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov. Meat Inspector (Veterinarian)</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Roanoke, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>A.M. WKE Ayers</b>				14. MOTHER'S MAIDEN NAME <b>Judson Peters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Unk</b>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Marie Ayers (Wife) 307 New York Ave. Salisbury, Maryland</b>		
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>1637</b>				<b>Carcinoma lung</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>19 55</b> , to <b>6-2</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-27</b> , 19 <b>57</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. Philip A. Insley</b>				ADDRESS (Street, city, town, state) <b>E. Main St. Salisbury, Maryland</b>		DATE SIGNED <b>June 3 / 57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 6, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		LOCATION (City, town, or county) (State) <b>Roanoke, Virginia</b>	
24. REC'D BY REGISTRAR DATE <b>JUN 5 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			

DEATH OF

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1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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BUREAU V. 8

JUN 5 1957

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*Journal of Interpersonal Violence* 26(10)

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**INSTRUCTIONS**

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**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06869

6922

# CERTIFICATE OF DEATH

Reg. Dist. No. 331

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		LENGTH OF STAY (In this place) <b>70 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RFD # 3</b>				STREET ADDRESS (If rural give location) <b>Maryland Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Christie Ann Bailey</b>				<b>4. DATE OF DEATH</b> (Month) <b>June</b> (Day) <b>22</b> (Year) <b>19 57</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 7, 1871</b>	<b>9. AGE last birthday</b> <b>85</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mardela Springs, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Thomas O. Goslee</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Jackson</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>222-05-9740</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Alvin S. Culver, Delmar, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE</b> (A) <b>Cerebral Hemorrhage</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>24 hours</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Cerebral Hemorrhage</b>				<b>3 mo.</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <b>Arteriosclerosis &amp; Hypertension</b>				<b>3 yrs</b>			
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>447X</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>June 20, 1957</u>, to <u>June 22, 1957</u>, that I last saw the deceased alive on <u>June 22, 1957</u>, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>L. H. Lynch</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Delmar, DE</i>		<b>DATE SIGNED</b> <i>6-23-57</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>6-25-57</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olive</b>		<b>LOCATION (City, town, or county)</b> <b>Delmar, Delaware</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUN 28 1957</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mary H. Holloway</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. S. Marvel Co. - Delmar, Del</i>		<b>ADDRESS</b>	



# CERTIFICATE OF DEATH

1957

Decedent's Name: **Barbara Evelyn**  
 Date of Birth: **Nov. 1, 1921**  
 Sex: **Female**  
 Race: **White**  
 Marital Status: **Married**  
 Date of Death: **June 28, 1957**  
 Place of Death: **Home**  
 Cause of Death: **Heart Disease**  
 Physician: **Dr. J. H. Smith**  
 Burial Place: **St. John's Cemetery**  
 Burial Date: **July 1, 1957**

Residence: **123 Main Street, Boston, Mass.**  
 Date of Birth: **Nov. 1, 1921**  
 Sex: **Female**  
 Race: **White**  
 Marital Status: **Married**  
 Date of Death: **June 28, 1957**  
 Place of Death: **Home**  
 Cause of Death: **Heart Disease**  
 Physician: **Dr. J. H. Smith**  
 Burial Place: **St. John's Cemetery**  
 Burial Date: **July 1, 1957**

Decedent's Name: **Barbara Evelyn**  
 Date of Birth: **Nov. 1, 1921**  
 Sex: **Female**  
 Race: **White**  
 Marital Status: **Married**  
 Date of Death: **June 28, 1957**  
 Place of Death: **Home**  
 Cause of Death: **Heart Disease**  
 Physician: **Dr. J. H. Smith**  
 Burial Place: **St. John's Cemetery**  
 Burial Date: **July 1, 1957**

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 Sex: **Female**  
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 Physician: **Dr. J. H. Smith**  
 Burial Place: **St. John's Cemetery**  
 Burial Date: **July 1, 1957**

BUREAU V. B.

JUN 28 1957

RECEIVED

AT OFFICE

6-28-57

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6350

## CERTIFICATE OF DEATH

06870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN 23X22</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>200 W. BROAD ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Emma DALLY BAILEY</b>				4. DATE OF DEATH <b>JUNE 12 1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 17, 1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>WILLARD STANTON BAILEY</b>		14. MOTHER'S MAIDEN NAME <b>EMMA FURBUSH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MISS MARY BAILEY</b>		Address <b>BERLIN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>444X Essential Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/20/57</b> , 19 <b>57</b> , to <b>6/11/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/10</b> , 19 <b>57</b> , and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David J. Gilman</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>June 11, 1957</b>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna R. Burbage</b>				ADDRESS <b>Berlin Md</b>		24a. RECEIVED BY REGISTRAR <b>JUN 13 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>May 22, 1957</b>	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NEW YORK

RECEIVED  
JUN 13 1957  
BUREAU V. S.



1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06871

6881

## CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wiconico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wiconico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		TOWN <b>Salisbury</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Men. Hospital</b>				STREET ADDRESS (If rural give location) <b>1924 S. Division St</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>HENRY</b> (Middle) <b>CARROLL</b> (Last) <b>BARNES</b>				(Month) <b>JUNE</b> (Day) <b>26th</b> (Year) <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>October 25, 1900</b>	9. AGE last birthday <b>56</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Henry C. Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Allen Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Samuel Stein (Daughter) 242 Woodland Road Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
177x IMMEDIATE CAUSE (A) <b>Congestive failure</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>carcinoma prostate</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/23</b> , 19 <b>57</b> , to <b>6/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/25</b> , 19 <b>57</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. Andrew C. Mitchell</b>				ADDRESS (Street, city, town, state) <b>M.D. Maryland Ave. (Office) Salisbury, Md.</b>			
DATE SIGNED <b>Jun. 27 1957</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 28, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR DATE <b>JUN 28 1957</b>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

# CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	

**RECEIVED**  
JUN 28 1957  
BUREAU V. S.

DISPOSITION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0332  
CERTIFICATE OF DEATH

07960  
Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Beebe's Ranch</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Beebe</u> Last <u>Beebe</u>				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ranch operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Silas Beebe</u>				14. MOTHER'S MAIDEN NAME <u>Arnthia Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ada Beebe - Chincoteague, Va.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>June 29</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Salinger</u>				M.D. <u>Salisbury, Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 2, 1957</u>		22c. NAME OF CEMETERY OR INTERMENTARY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salinger</u>				24a. REC'D BY REGISTRAR DATE <u>7-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary D. Holloman</u>	

BUREAU V. M.

JUL 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06872

Reg. Dist. No.

337

6883

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>733 S. Division St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>PRESTON</b> Last <b>BETTS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 6, 1912</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b>11</b> Min. <b>18</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Workman Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sussex Co. Delaware</b>			
11. BIRTHPLACE (State or foreign country) <b>U S A</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>William Betts</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Records</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Arthur D. Betts (Brother)</b>			
				17. ADDRESS <b>312 E. Vine St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>541.0</b> DUE TO <b>Spontaneous Pulsen</b> Conditions, if any, which gave rise to immediate cause (b) <b>undetermined</b> (c) <b>undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>undetermined</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Emil L. Royer</b>				DATE SIGNED <b>June 25 1957</b>			
EXAMINER'S NAME (Type) <b>Dr. Emil L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>Wey J. Holloway</b>			



RECEIVED  
JUN 28 1957  
BUREAU V. S.

6884

## CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>#35 Cherry Way</b>			
3. NAME OF (First) (Middle) (Last) <b>JAMES MATTHEW BRADLEY</b> (Type or Print)				4. DATE (Month) (Day) (Year) <b>DEATH JUN 28 th 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Baby</b>	8. DATE OF BIRTH <b>12:16P.M. Jun. 27th, 1957</b>		9. AGE last birthday <b>0</b> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md. Hospital</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lou Gehrig Bradley</b>				14. MOTHER'S MAIDEN NAME <b>Violet A. Greene</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Mr. Lou G. Bradley (Father) #35 Cherry Way Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Congestive Failure</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Coronary Heart Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Myocardial Infarction, etc.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify, that I attended the deceased from <b>6/27/57</b> , 19 <b>57</b> , to <b>6/28/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/28/57</b> , 19 <b>57</b> , and that death occurred at <b>12:25A</b> , from the causes and on the date stated above. <b>Signature Dr. William Smith</b> M.D. <b>Medical Center Salisbury, Maryland Jun 28/57</b> ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jun. 29, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>		LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b> ADDRESS			
DATE <b>JUN 1 1957</b>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

BUREAU V. S.

JUL 1 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the State Health Department. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee, agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
SM 7/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06874

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN <u>Salisbury</u> (If outside of corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
c. LENGTH OF STAY IN TB <u>life</u>			d. STREET ADDRESS <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Green Brook</u>					
3. NAME OF DECEASED (Type or print) <u>Eliah Jeroniah Brown</u>			4. DATE OF DEATH <u>6-2-57</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26-39</u>	9. AGE (in years last birthday) <u>18</u> yrs	10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		
11. BIRTHPLACE (State or foreign country) <u>2nd</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Elijah Brown</u>			14. MOTHER'S MAIDEN NAME <u>Lena Dashiield</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>			16. SOCIAL SECURITY NO. <u>?</u>		
17. INFORMANT <u>Elijah Brown, Salisbury, Md</u>			Address <u>Salisbury, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>1 x 7.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>?</u> (c) <u>?</u> DUE TO cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			20c. TIME OF INJURY Month, Day, Year <u>5:30 P.M. 6-2-57</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury</u>		
20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>			21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>Earl L. Royce</u>			DATE SIGNED <u>7-1-57</u>		
EXAMINER'S NAME (Type) <u>Earl L. Royce, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. DATE OF CREMATION <u>6-30-57</u>			22b. DATE THEREOF <u>7th</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico</u>			22d. LOCATION (City, town, or county) <u>Salisbury</u> (State) <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>			24. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		

JUL 5 1957

RECEIVED

JUL 5 1957

BUREAU V. 3





RECEIVED

JUN 13 1957

BUREAU V. S.

RECEIVED

6887

CERTIFICATE OF DEATH

06876

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula Gen. Hospital</b>				d. STREET ADDRESS <b>WASHINGTON 2106 MINNISOTA AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>O. FRANK</b> First Middle Last				4. DATE OF DEATH <b>JUNE 26 1957</b> Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29th 1895</b>	
				9. AGE (n years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Moses F. Burgess</b>				14. MOTHER'S MAIDEN NAME <b>Alice Hanback</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Louise F. Burgess</b> Address <b>2106- Minn., Ave. S. E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarct, acute</b> 4 2... DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-28-57</b> , to <b>6-26-57</b> , that I last saw the deceased alive on <b>6-24-57</b> , and that death occurred at <b>9 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William B. Elbert</b> M.D. <b>Salisbury, Md.</b> <b>6-26-57</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29- 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmon Bros.</b> ADDRESS <b>1661- Good Hope Road S.E. Washington 20, D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Williams</b>	

RECEIVED  
JUN 28 1957  
BUREAU V. A.

6888

## CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 1/4/52</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crisfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (If rural give location) <u>Main Street Extended</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Cordelia</u> <u>--</u> <u>Custis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>28</u> <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10, 1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anancock, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Hundley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic glomerular Nephritis</u>				<u>1956</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Inactive, <del>active</del> pulmonary tuberculosis</u>				<u>1952</u>			
19a. DATE OF OPERATION <u>CO2X</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>52</u> , to <u>June 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
DATE SIGNED <u>6/28/57</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 30/57</u>		NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>JUL 2 1957</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the final copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



BUREAU V. 2

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RECEIVED

6889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Princess Anne</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>11-14-55</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Private Sanitarium</b>			d. STREET ADDRESS <b>Springhill Road</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Dashiell</b> Last <b>Dashiell</b>			4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1872</b>		9. AGE (in years last birthday) yrs. <b>84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Northampton, Va.</b>	
13. FATHER'S NAME <b>Charles Smith</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Wilson Jacob</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Irgine Plinn Newark, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aneurism of femoral artery</b> <b>452X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. p.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-14</b> , 19 <b>55</b> , to <b>6-3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-3</b> , 19 <b>57</b> , and that death occurred at <b>5:45</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Philip A. Tinsley</b> M.D.					
PHYSICIAN'S NAME (Type) <b>Philip A. Tinsley Salisbury, Md. 1-3-57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-6-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Learn R. McLean</b>			ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 10 1957</b>
					24b. REGISTRAR'S SIGNATURE <b>Harry H. Hallman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6923

## CERTIFICATE OF DEATH

06879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Haven</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Granville R. Dashiell</b>				4. DATE OF DEATH <b>June 14 1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1875</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Colab Dashiell</b>				14. MOTHER'S MAIDEN NAME <b>Sollie Jane Darby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-36-0749</b>		17. INFORMANT <b>Edna Dashiell</b> Address <b>White Haven, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Gravely Ill</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis</b> (c) <b>Generalized Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10 JAN. 1948</b> to <b>14 June 1957</b> that I last saw the deceased alive on <b>14 June 1957</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard H. Spunders</b> M.D. <b>Nanticoke Md.</b>				DATE SIGNED <b>15 June 57</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD H. SPUNDERS</b>				<b>NANTICOKE Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dolby Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>White Haven Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Preece</b> ADDRESS <b>...</b>				24a. REC'D BY REGISTRAR <b>JUN 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Halliway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED



6924

CERTIFICATE OF DEATH

06881

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Haven</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lula</u> First <u>M.</u> Middle <u>Molbey</u> Last				4. DATE OF DEATH <u>June</u> Month <u>4</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 20 1881</u> Age (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen Molbey</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Simpkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or only in <u>no</u> ) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Vance Molbey White Haven Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronial Heart overage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3 June 1957</u> to <u>4 June 1957</u> that I last saw the deceased alive on <u>5 June 1957</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders M.D.</u>				ADDRESS (Street, city or town, state) <u>Wicomico Md</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. SAUNDERS M.D.</u>				DATE SIGNED <u>6/7/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Molbey Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Haven Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Linn</u> ADDRESS <u>Wicomico Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary H. Linn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12 1957

BUREAU V. S.

JUN 12 1957

RECEIVED

6890

## CERTIFICATE OF DEATH

Reg. Dist. No. 327

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>605 East Church St.</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>MARY</b>		(Middle) <b>ANNA</b>		(Last) <b>DRYDEN</b>		(Month) <b>JUNE</b> (Day) <b>1</b> (Year) <b>1957</b> DEATH <b>JUNE 1 ST 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 13, 1875</b>	9. AGE last birthday <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Washington Riffin</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <b>Mrs. Carrie M. Dryden Colonna (Daughter) 210 Truitt St. Salisbury, Maryland</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Arteriosclerosis</b>						<b>15 yrs</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 <b>42</b> to <b>6/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/1/57</b> , 19 <b>57</b> , and that death occurred at <b>11:30 P.</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Dr. Fred Gramse</b>				DATE SIGNED <b>June 3 / 57</b>			
ADDRESS (Street, city, town, state) <b>M.D. S. Division St. Salisbury, Maryland</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 4, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<b>HOLLOWAY &amp; COMPANY</b>		<b>SALISBURY MARYLAND</b>	

V5 AISC 1-55 TOM

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED  
JUN 5 1957  
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06883

6925

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury (Rural)</b>		LENGTH OF STAY (in this place)		CITY OR TOWN <b>Salisbury (Rural)</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D.# 3 (Old Delmar Rd U.S.#13)</b>				STREET ADDRESS <b>R.D.# 3</b>			
3. NAME OF DECEASED (Type or Print) <b>LEMUEL JAMES ELLIOTT</b>				4. DATE OF DEATH <b>JUNE 26th 19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>December 23, 1886</b>	
9. AGE last birthday <b>70</b> yrs.		10. IF UNDER 1 YEAR <b>6</b> Months <b>3</b> Days		11. IF UNDER 24 HRS. <b>3</b> Hours <b>Min.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming (Nursery)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex County Delaware</b>	
13. FATHER'S NAME <b>Asbury Elliott</b>				14. MOTHER'S MAIDEN NAME <b>Laura Perdue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218 - 20 - 3640</b>		17. INFORMANT & ADDRESS <b>Mrs. Julia A. Elliott (Wife) R.D.# 3 (Old Delmar Rd) Salisbury, Maryland</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Acute Congestive Cardiac Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Asthma</b>				3 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 26, 1957</b> , to <b>June 27, 1957</b> , that I last saw the deceased alive on <b>June 26, 1957</b> , and that death occurred at <b>4:10 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. S. Howard Lynch</b>				ADDRESS (Street, city, town, state) <b>M.D. Delaware Ave. Delmar, Delaware</b>			
DATE <b>JUN 28 1957</b>				DATE SIGNED <b>Jun. 27 / 57</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 29, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. RECORD BY REGISTRAR <b>Mary H. Holloway</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY * SALISBURY, MARYLAND</b>			

RECEIVED  
JUN 28 1957  
BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6926

## CERTIFICATE OF DEATH

06884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. SEAFORD, DEL</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>RFD #3 09X12</u>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>DRUCILLA W. Eastridge</u>			4. DATE OF DEATH Month <u>6</u> - Day <u>4</u> - Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOSHUA WILLIAMS</u>			14. MOTHER'S MAIDEN NAME <u>HETTIE TIMMONS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>  </u>		
17. INFORMANT <u>WILLIAM J. ESKRIDGE, SEAFORD, DEL</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unemia.</u>					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>Pyelonephritis, bilateral, chronic</u>					<u>10-12 yrs.</u>
DUE TO					
(c) <u>Staghorn calculus, left kidney</u>					<u>10-12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Atherosclerotic heart disease</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>MAY 29</u> , 1957, to <u>JUNE 4</u> , 1957, that I last saw the deceased alive on <u>JUNE 4</u> , 1957, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Raymond M. York</u> M.D. <u>207 Camden Ave. Salisbury, MD 6-4-57</u>					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>6-9-1957</u>		<u>ST JOHNS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. RECEIVED BY REGISTRAR DATE	
<u>Charles W. Arnold, Shafter, Md.</u>		<u>  </u>		<u>JUN 10 1957</u>	
24b. REGISTRAR'S SIGNATURE		<u>  </u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6927

CERTIFICATE OF DEATH

06885

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>	
d. NAME OF HOSPITAL (if not in hospital, give street address) <b>600 State Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry Gibson</b>		4. DATE OF DEATH Month Day Year <b>June 7 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1882</b>
9. AGE (in years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal &amp; Oil</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph W. Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Lida Seward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-222276</b>	
17. INFORMANT <b>Laura Gibson, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary (Heart)</b> 334x DUE TO <b>Arterio Sclerosis (Heart muscle Condition)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>18 m</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1957</b> to <b>June 10, 1957</b> that I last saw the deceased alive on <b>June 7, 1957</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Del.</b> DATE SIGNED <b>June 10, 1957</b>			
ACTUAL SIGNATURE <b>H. H. Lynch</b> M.D. <b>Delmar, Del.</b>		PHYSICIAN'S NAME (Type) <b>H. H. Lynch</b>	
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-57</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Marshall Co., Delmar, Del.</b>		24. REC'D BY REGISTRAR DATE <b>JUN 12 57</b>	
25. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>		26. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>	

RECEIVED  
JUN 12 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6891 CERTIFICATE OF DEATH

06886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ADDILADE</b>		First Middle Last <b>GRIFEITH</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 15 1871</b>	
9. AGE (In years last birthday) yrs <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Robinson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>		17. INFORMANT <b>Mr Susan Costen Allen</b>		Address <b>Salisbury Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis &amp; hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William H. Fisher M.D.</b>				ADDRESS (Street, city or town, state) <b>Salisbury Md.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6-5-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>				ADDRESS <b>Primer Avenue</b>		24a. REC'D BY REGISTRAR <b>JUN 10 1957</b>	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

JUN 10 1957

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No. 27

6892

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>R.D.# 4 (Snow Hill Rd)</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>GRACE</b>		(Middle) <b>ESTELLA</b>		(Last) <b>HALL</b>		(Month) <b>JUNE</b> (Day) <b>9th</b> (Year) <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Sept. 19, 1899</b>	9. AGE last birthday <b>57</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Victor Lynn Lines (Employee)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry O. Hall</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Stevenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Elizabeth E. Hall (Mother) R.D.# 4 (Snow Hill Rd) Salisbury, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<b>Cerebral Hemorrhage</b>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955 to 6-10, 1957, that I last saw the deceased alive on 6-10, 1957, and that death occurred at 9:40P.M. from the causes and on the date stated above.							
SIGNATURE <b>Dr. Philip A. Insley</b>				ADDRESS (Street, city, town, state) <b>Main St. Salisbury, Maryland</b>		DATE SIGNED <b>June 16 1957</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial -</b>		DATE THEREOF <b>Jun 13, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>JUN 13 1957</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 MM.

BUREAU V. 5

1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

06888

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Accomac</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chincoteague</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL Hospital</b>		d. STREET ADDRESS <b>8. Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Dean</b> Last <b>HALL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>12<sup>th</sup></b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9<sup>th</sup> 1957</b>
9. AGE (In years, lost birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Richard Hall</b>		14. MOTHER'S MAIDEN NAME <b>Winifred Watson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Richard Hall</b>		Address <b>Chincoteague, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Terminal</b> <b>'735</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anoxia, Fetal, of Brain and Organs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prematurity</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-9</b> , 1957, to <b>12 June</b> , 1957, that I last saw the deceased alive on <b>12 June</b> (1957), and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. W. Sullivan</b>		ADDRESS (Street, city or town, state) <b>926 N. Division St. Salisbury Md</b>	
DATE SIGNED <b>6/12/57</b>			
PHYSICIAN'S NAME (Type) <b>William B. Salyer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 14, 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mechanic Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Chincoteague, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Salyer</b>		ADDRESS <b>Chincoteague, Va.</b>	
24a. REC'D BY REGISTRAR <b>DATE 6-22-57</b>		24b. REGISTRAR'S SIGNATURE <b>Maryll Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUN 25 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6894

CERTIFICATE OF DEATH

Reg. Dist. No.

86889

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
c. LENGTH OF STAY IN 1b <b>14 months</b>				d. STREET ADDRESS <b>Route # 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>W.</b> Last <b>Hartwig</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1876</b>	9. AGE (In years last birthday) yrs. <b>80</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>25</b> Hours <b>57</b>	IF UNDER 24 HRS Months <b>8</b> Days <b>25</b> Hours <b>57</b>	Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Hartwig</b>				14. MOTHER'S MAIDEN NAME <b>Williamima Kurtz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>102-18-4641A</b>		17. INFORMANT <b>Mr. George Ryan (Son-in-Law)</b>		18. S. Broad St <b>Ridgewood N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis general</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 1956</b> , to <b>June 25, 1957</b> , that I last saw the deceased alive on <b>June 24, 1957</b> , and that death occurred at <b>12:30AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>				DATE SIGNED <b>6/25/57</b>			
ACTUAL SIGNATURE <b>V. Juelman</b>				M.D. <b>Salisbury, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>V. Juelman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>J. William Lees</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway and Co.</b>				ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>1 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary T. Holloway</b>			

RECEIVED

JUL 1 1957

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06890

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6895

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>R.D.# 4 Ocean City Blvd.</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>MARY IVA HASTINGS</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>June 6 th 19 57</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Feb. 28th, 1878</b>	<b>9. AGE last birthday</b> <b>79 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Somerset Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Louis White Pusey</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Priscella Pusey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Preston Jones (Daughter)</b> <b>Newark, Maryland</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <b>4 am</b> <b>Pyenteric Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Heart Disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 6, 1957, to June 6, 1957, that I last saw the deceased alive on June 6, 1957, and that death occurred at 4:15 P.M. from the causes and on the date stated above.</b> <b>SIGNATURE Dr. David J. Gilmore</b> ADDRESS (Street, city, town, state) DATE SIGNED <b>June 7/57</b> <b>M.D. Medical Center - Salisbury, Maryland</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>June 9, 1957</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Salisbury, Maryland</b>	
<b>24. RECEIVED BY REGISTRAR</b> <b>JUN 10 1957</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			

BUREAU V. S.

JUN 10 1957

RECEIVED

6928

## CERTIFICATE OF DEATH

06891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN 1b <b>61 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>205 Chestnut</b>		e. STREET ADDRESS <b>205 Chestnut</b>	
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Elizabeth</b> Last <b>Hastings</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William A. Culver</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Fitzgerald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>C. Edgar Hastings, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic and hypertensive heart disease - pulmonary edema.</b> DUE TO (b) <b>arteriosclerosis general. Hypertension.</b> DUE TO (c) <b>chronic pyelonephritis + chronic uremia - post. fever</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic pyelonephritis + chronic uremia - post. fever</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-6-57</b> to <b>6-6-57</b> , that I last saw the deceased alive on <b>6-6-57</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delmar, Md.</b> DATE SIGNED <b>6-7-57</b> ACTUAL SIGNATURE <b>L.V. Sohler</b> M.D. PHYSICIAN'S NAME (Type) <b>L.V. Sohler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Marvel Co. - Delmar, Del.</b>		24a. REC'D BY REGISTRAR <b>DATE 10 10 57</b>	
24b. REGISTRAR'S SIGNATURE <b>H. V. Williams</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN 10 1957

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

6896

06892

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 2/11/52</u>		CITY OR TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS <u>110 Circle Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Paul Everett Hayman</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 28 19 57</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 17, 1889</u>	<b>9. AGE last birthday</b> <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year) <u>8 11 57</u>	<b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Doorkeeper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>American Legion</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Salisbury, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Hayman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Tindle</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-10-6724</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Perry Ragains (Daughter) Milford, Del.</u> <u>Deceased when admitted to hospital</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) <u>Cor</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis - Far Advanced</u>				<u>8 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>4.2/1/5</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Feb. 11, 19 52</u> <b>to</b> <u>June 28, 19 57</u> <b>that I last saw the deceased alive on</b> <u>June 28, 19 57</u> <b>and that death occurred at</b> <u>10:15 AM</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. S. H. Biddle</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Maryland</u>		<b>DATE SIGNED</b> <u>6/28/57</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>June 30, 1957</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Fruitland, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mary A. Holloway</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</u>			

BUREAU V. S.

RECEIVED

Library

1951



6929

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>DOLLIE</b> Middle <b>MILINDA</b> Last <b>HEARNE</b>				4. DATE OF DEATH Month <b>6</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1872</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Robert H. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Miria J. Hayman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Ira F. Hearne</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>44-2A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Insufficiency</b> (c) <b>Hypertensive C.V. Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1-1-1957</b> to <b>6-14-1957</b> , that I last saw the deceased alive on <b>6-13-1957</b> , and that death occurred at <b>5:14 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Center, Salisbury, Md.</b> DATE SIGNED <b>6/14/57</b> ACTUAL SIGNATURE <b>W. B. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>William B. Smith</b> <b>Medical Center, Salisbury, Md.</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/15/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsborg Cemtery</b>		22d. LOCATION (City, town, or county) (State) <b>Parsonsborg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Md.</b>				42a. REC'D BY REGISTRAR DATE <b>6-17-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>	

Norman B. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 18 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6930

## CERTIFICATE OF DEATH

06894

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetipquin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY G. HORNER</u>				4. DATE OF DEATH Month Day Year <u>June 13 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1881</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>7 20</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis C. Horner</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Louis Horner, Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Syncope</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/17/57</u> , 19 <u>57</u> , to <u>5/17/57</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Saunders</u>				DATE SIGNED <u>6/15/57</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u>				ADDRESS (Street, city or town, state) <u>Nanticoke, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wetipquin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Wetipquin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Bivalve</u>				ADDRESS <u>Bivalve, Maryland</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>Mary T. Bivalve</u>				DATE <u>JUN 25 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

RECEIVED  
JUN 25 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6897

## CERTIFICATE OF DEATH

068957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WARCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>MARKET STREET</u>			
3. NAME OF DECEASED (Type or print) <u>Charles M. Hudson</u>				4. DATE OF DEATH <u>June 7 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 9, 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHEMIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>MR. J. HUDSON SR.</u>				14. MOTHER'S MARDEN NAME <u>EMMA A. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS ELIZABETH M. HUDSON, POCOMOKE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Dilatation of Heart</u> DUE TO <u>Since Anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spl. Hepatic Hemis</u> DUE TO (c) <u>Spl. Hepatic Hemis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>88 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-29</u> , 19 <u>57</u> , to <u>6-7</u> , 19 <u>57</u> , that I lost the deceased on <u>6-7</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Abriele</u>				ADDRESS (Street, city or town, state) <u>Mulford Center</u> DATE SIGNED <u>6. 8. 57</u>			
PHYSICIAN'S NAME (Type) <u>H. Abriele</u>				ADDRESS <u>Salisbury Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GIRDLETREE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Watson</u> ADDRESS <u>POCOMOKE, MD.</u>				24a. REC'D BY REGISTRAR <u>JUN 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Way</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 12 1957  
BUREAU V. S.

6898

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Hudson</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29 - 1956</u>	
9. AGE (In years, last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>21</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>							
13. FATHER'S NAME <u>William Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Julia Park</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mrs. Julia P. Hudson, Pottsville, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rural #1</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/19</u> , 19 <u>57</u> to <u>6/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Salisbury, md</u>				DATE SIGNED <u>6/20/57</u>			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.							
NAME (Type) <u>William C. Morgan</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Rural #2 md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Morris</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>June 24 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 24 1957  
BUREAU V. S.



6931

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pittsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville Rural</b>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D.# 1</b>				STREET ADDRESS (If rural give location) <b>R.D.# 1</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>ARRIA MAY HUNTINGTON</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 22 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 6, 1883</b>		9. AGE last birthday <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsville Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Smiley J. Wells</b>				14. MOTHER'S MAIDEN NAME <b>Lwvenia Parsons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. George W. Huntington (Husband) R.D.# 1 Pittsville, Maryland</b>		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Myocarditis Chronic (2 yrs)</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<b>Fractured surg. neck. Left hip 1 year 2 yrs ago</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1955</b> , 19... to <b>6-22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-21</b> , 19 <b>57</b> , and that death occurred at <b>4:49</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Dr. Frank B. Lewis</b>				ADDRESS (Street, city, town, state) <b>Willards, Maryland</b>		DATE SIGNED <b>June 24 1957</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jun. 25, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			
DATE <b>JUN 25 1957</b>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. E.

JUN 25 1957

RECEIVED

06896

6899  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NANTICOKE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>W.</u> Last <u>INSLEY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Esau Insley</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Levin Wilson Princess ANNE, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative heart disease</u> <u>422.20</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>autism</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/24/1957</u> , to <u>6/3/1957</u> , that I last saw the deceased alive on <u>6/3/57</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>W. B. Ellis</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Insley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bivalve, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1957</u>	
ADDRESS <u>Princess Anne, Md.</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 10 1957  
BUREAU V. S.

6900

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chance,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Chance,</u>	
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Maurice</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Negro</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1951</u>
9. AGE (In years last birthday) <u>6</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Catherine Leonard</u>		Address <u>Chance, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Appendix</u> DUE TO (b) <u>Acute Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>2 days</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>June 16, 1957</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldon G. Markman, M.D.</u>		ADDRESS (Street, city or town, state) <u>Princess Anne, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Eldon G. Markman</u>		DATE SIGNED <u>Princess Anne, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>	22d. LOCATION (City, town, or county) (State) <u>Chance, Som. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md.</u>	24a. REC'D BY REGISTRAR <u>DATE 6-26-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 28 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06900

CERTIFICATE OF DEATH

Reg. Dist. No.

337

6901

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PRESTON</b> Middle <b>WILLIAM</b> Last <b>KILLMON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>28th</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1924</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Operator (Bait &amp; Tackle-Sporting Goods)</b>	
11. BIRTHPLACE (State or foreign country) <b>Newark, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Seamer Killmon</b>		14. MOTHER'S MAIDEN NAME <b>Mannie Bradford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. II</b>		16. SOCIAL SECURITY NO. <b>W.W. II</b>	
17. INFORMANT <b>Mrs. Anna Bella Killmon (Wife)</b>		Address <b>Pierce St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lymphosarcoma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>4 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October, 1956</b> to <b>June, 1957</b> , that I last saw the deceased alive on <b>June 28, 1957</b> , and that death occurred at <b>6:55 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas C. Hill Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>924 N. Division Street Salisbury, Maryland</b>	
DATE SIGNED <b>6/28/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 1, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary H. Harrison</b>	

BUREAU V. S.

JUL 1 1957

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06901

Reg. Dist. No.

6902

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>KOFFEL</b> Last <b>KOFFEL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>22</b> Year <b>19 57</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1st, 1882</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR: Months <b>10</b> Days <b>21</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wico. County - Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Milbourne Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Hitchens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Raymond Koffel (husband)</b> Address <b>316 Carroll St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>704.0</b> DUE TO <b>Heart Congestion / Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left hip</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Fell at home 6-5-57</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> o. m. <b>5</b> p. m. <b>1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Spec. by) <b>Burial</b>				22b. DATE THEREOF <b>Jun. 24, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>				(State) <b></b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Marjorie Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 26 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06902  
337

6903

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Essex, V.</u> b. COUNTY <u>Essex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. LENGTH OF STAY IN 1b <u>51 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Hill Sanatorium</u>		d. STREET ADDRESS <u>Essex, Va.</u>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Linkford</u> Middle <u>L</u> Last <u>Linkford</u>		4. DATE OF DEATH <u>June 10</u> 19 <u>57</u> Month <u>6</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Linkford</u>		14. MOTHER'S MAIDEN NAME <u>Emily Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr Charles Linkford Essex, Va.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 5</u> 19 <u>57</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>6-17-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Franktown</u>	22d. LOCATION (City, town, or county) (State) <u>Franktown Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ford James R.B. Fox Eastville</u>		24a. REC'D BY REGISTRAR <u>JUN 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Williams</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Registrar of Health or its designee, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 19 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

6904

0691337

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>720 Greenwood Road</u>			• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Johanna</u> Middle <u>Lilly</u> Last <u>Lilly</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>28</u> Year <u>19 57</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 5, 1891</u>							
<b>9. AGE</b> (In years lost birthday) <u>65</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.				
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
	Hours												
	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore</u>							
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>Edward Bartling</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Johanna Kreueler</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hospital Records</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]													
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>  <u>?</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Old C V A</u>													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <u>6/21/</u> <u>19 57</u> , to <u>6/28/</u> <u>19 57</u> , that I last saw the deceased alive on <u>6/28/</u> <u>19 57</u> , and that death occurred at <u>8:35</u> AM, from the causes and on the date stated above.													
<b>ACTUAL SIGNATURE</b> <u>L. V. Maldve</u> M.D.				<b>DATE SIGNED</b> <u>6/28/57</u>									
<b>PHYSICIAN'S NAME (Type)</b> <u>L. V. Maldve, M.D.</u>				<u>Salisbury, Maryland</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 2/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore 29</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke Funeral Directors, 4101 Edmondson Ave.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 1 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Ray H. Holloway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

BUREAU V. E.

JUL 1 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6905

06904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Zion Rd</b>		e. STREET ADDRESS <b>Hudson Drive</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN WILLIAM DAVID LITTLETON JR</b>		4. DATE OF DEATH <b>June 11 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1950</b>
9. AGE (In years last birthday) <b>6</b> yrs.		10. IF UNDER 1 yr <b>9</b> Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>School Boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>John William David Littleton</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Mr. &amp; Mrs. J. Wm David Littleton (Mother &amp; Father)</b>	
17. INFORMANT <b>Hudson, Drive Salisbury, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Fracture of skull</b>		DUE TO (b) <b>12X</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by car</b>	
20c. TIME OF INJURY <b>7:15 p.m. 6-11 1957</b>	20d. INJURY OCCURRED <b>While at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Zion Rd</b>	20f. CITY OR TOWN (County) (State) <b>Salisbury Wicomico Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 12 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jun. 15, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY MD.</b>		24a. REC'D BY REGISTRAR <b>JUN 13 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

RECEIVED  
JUN 13 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6906

## CERTIFICATE OF DEATH

06905

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN TB <b>2 1/3 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>			
f. STREET ADDRESS <b>Oremton Farm</b>				g. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>THEAESA</b> Last <b>McDonough</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/9/1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Albany, New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John T. McDonough</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Wallace</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>- No</b>				16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypostatic congestion of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Volvulus of the intestine</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 22</b> , 19 <b>55</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 9</b> , 19 <b>57</b> , and that death occurred at <b>6:48 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/10/57</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b> <b>Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>JUNE 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. AGNES CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ALBANY, NEW YORK</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Gault</b>				ADDRESS <b>EASTON, M.D.</b>		24a. REC'D BY REGISTRAR <b>JUN 14 57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Hampton Gault</b>							



BUREAU V. 31

JUN 14 1957

RECEIVED

6907

## CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>101 Tingle Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Hester</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1893</b>		9. AGE (In years last birthday) <b>64</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Bishop</b>				14. MOTHER'S MAIDEN NAME <b>Martha Selby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inoperable mixed tumor of sarcoma and carcinoma</b> DUE TO <b>of the uterus with advanced generalized metastases.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 8, 1957</b> , to <b>June 14, 1957</b> , that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/14/57</b>							
ACTUAL SIGNATURE <b>S. Juerman</b>			M.D. <b>Deer's Head State Hospital</b>				
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>			Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial June 18/57</b>		<b>June 18/57</b>		<b>Huts Chapel</b>		<b>Snow Hill, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>May &amp; Tremm</b>			ADDRESS <b>Snow Hill, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>May J. Williams</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 18 1957

BUREAU OF

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06907

6932

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wiconico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wiconico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hebron</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hebron</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Lillian St (At Home)</b>				STREET ADDRESS (If rural give location) <b>Lillian St (At Home)</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. DATE OF DEATH	
(First) <b>WILLIAM</b> (Middle) <b>STEPHEN</b> (Last) <b>MILLS</b>				(Month) <b>JUNE</b> (Day) <b>8th</b> (Year) <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 14, 1887</b>	9. AGE last birthday <b>70</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer in Lumber Mill</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Wiconico Co. Near Hebron, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Rufus Mills</b>				14. MOTHER'S MAIDEN NAME <b>Phillis Bradley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Unk</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Katie L. Mills (Wife) Lillian St. Hebron, Maryland</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>coronary thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 8, 1957</b> to <b>June 11, 1957</b> , that I last saw the deceased alive on <b>June 8, 1957</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Dr. William E. Erick</b>				ADDRESS (Street, city, town, state) <b>M.D. Main St. Hebron, Maryland</b>		DATE SIGNED <b>June 10 / 57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 11, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Hebron Cemetery</b>		LOCATION (City, town, or county) (State) <b>Hebron, Maryland</b>	
24. REC'D BY REGISTRAR <b>JUN 12 1957</b>		REGISTRAR'S SIGNATURE <b>Mary E. Harrison</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom part may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate must be detached for use as a burial transit form.

VS A15C 1-15 10M.

RECEIVED  
JUN 20 1957  
BUREAU V. S.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06908

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Rural Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD # 4</u>		d. STREET ADDRESS <u>RFD # 4</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Henry</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1880</u>
9. AGE (in years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Clayton C. Parker</u>		14. MOTHER'S MAIDEN NAME <u>Maria Leonard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>015-38-0065</u>	
17. INFORMANT <u>Mrs. Joseph Parker, Sr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>p</u> m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>6-12-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/16/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. Salisbury, Maryland</u> <u>Norman B. Baker</u>		24a. REC'D BY REGISTRAR <u>6-17-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

RECEIVED

JUN 18 1957

BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6908

## CERTIFICATE OF DEATH

06999

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>6 Mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Penninsula Gen. Hosp</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b>			
f. STREET ADDRESS <b>615 North 48th St.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Ola Parson</b>				4. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>F.M.</b>	6. COLOR OR RACE <b>AA</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1892</b>	9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Pinkett</b>				14. MOTHER'S MAIDEN NAME <b>Leah Ann Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>078 16 7483</b>		17. INFORMANT Address <b>Mrs. Jean Spence, 648 W. Main St., Salisbury, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular Renal Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Indefinite</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 7. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>24 May 1957</b> , to <b>23 June 1957</b> , that I last saw the deceased alive on <b>23 June 1957</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>E. A. Purnell</b>				ADDRESS (Street, city or town, state) <b>652 W Main St, Salisbury, Maryland</b>			
DATE SIGNED <b>23 June 57</b>							
PHYSICIAN'S NAME (Type) <b>E. A. Purnell, 652 W. Main Street</b>				<b>Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Lam Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharon Hill, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Stewart Funeral Home, Salisbury, Maryland</b>				ADDRESS <b>Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 26 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary J. Salisbury</b>			

BUREAU V. E.

JUN 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6909

## CERTIFICATE OF DEATH

Reg. Dist. No.

06910

237

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>PATRICIA ALICE Phillips</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1st 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 MRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT PHILLIPS</u>				14. MOTHER'S MAIDEN NAME <u>SHIRLEY LUDLAM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS ROBERT PHILLIPS BERLIN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, intracerebral</u> <u>1604</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia (Birth Weight 1 lb 10 oz)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>10:52 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>976 N Division St Salisbury MD</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury MD</u>				DATE SIGNED <u>12 June 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PHILLIPS PRIVATE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN (RED) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u>				ADDRESS <u>Berlin MD</u>		24a. RECEIVED BY REGISTRAR DATE <u>JUN 17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. S.

JUN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6910

Item 1, 11-17, 7-2-57 et  
 CERTIFICATE OF DEATH

Reg. Dist. No.

06911337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>			
c. LENGTH OF STAY in lb <u>5yrs.3mo.</u>				d. STREET ADDRESS <u>412 W. Chester St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Richardson</u> Last <u>Pohler</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk. Salesman Spda Supplies</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Herman Pohler</u>			
14. MOTHER'S MAIDEN NAME <u>Louise Ruths</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>			
16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT <u>Deer's Head Hospital Records, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, Md.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>March 31, 1952</u> , to <u>June 26, 1957</u> , that I last saw the deceased alive on <u>June 26, 1957</u> , and that death occurred at <u>9:15A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6/26/57</u> ACTUAL SIGNATURE <u>J. Juerman</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Juerman, M. D.</u> <u>Deer's Head State Hospital, Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				24a. REC'D BY REGISTRAR <u>JUN 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Followay</u>	

RECEIVED  
JUN 28 1957  
BUREAU Y. S.

6911 State of Maryland DEPARTMENT OF HEALTH—BALTIMORE, 18  
 6911 iter 7 P. 1-2-3 et  
**CERTIFICATE OF DEATH**

06912  
 337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>Sussex</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Pine Street</b>			
3. NAME OF DECEASED (Type or print) <b>Thomas W. Records</b>				4. DATE OF DEATH <b>June 13-1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 21, 1886</b>	9. AGE (In years last birthday) <b>80</b> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Meat &amp; Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Thomas S. Records</b>				14. MOTHER'S MAIDEN NAME <b>Nancy V. Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>MAMIE M. RECORDS</b>				Address <b>LAUREL, Del</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforated &amp; Bleeding Peptic ulcer</b> DUE TO <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 mon</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-18</b> , 19 <b>57</b> , to <b>6-13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-13</b> , 19 <b>57</b> , and that death occurred at <b>8:58</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H A Brielle</b>				ADDRESS (Street, city or town, state) <b>Medical Center</b>			
PHYSICIAN'S NAME (Type) <b>H A Brielle</b>				DATE SIGNED <b>6-13-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Fellows Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>LAUREL, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>V. Henry Williams</b>				ADDRESS <b>Fredericksburg, Va.</b>		24a. REC'D BY REGISTRAR <b>June 17, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Thos. F. Williams</b>			

RECEIVED

JUN 17 1957

BUREAU V. S.



1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06913

6912

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pen. Gen. Hospital</b>				STREET ADDRESS (If rural give location) <b>147 Clyde Ave</b>			
3. NAME OF DECEASED (Type or Print) <b>IVY SINDEL</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 22nd 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Mar. 22, 1889</b>	9. AGE last birthday <b>68</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Candy Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Candy</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Sindel</b>				14. MOTHER'S MAIDEN NAME <b>Cordelia Cassel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. James W. Cassel (Nephew) 147 Clyde Ave Salisbury, Maryland</b>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary edema</b>				12 hrs			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized lymphosarcoma</b>				8 mos			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb. 19 57</b> to <b>June 19 57</b> , that I last saw the deceased alive on <b>June 22 19 57</b> , and that death occurred at <b>5:15A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. Alberta Mattox</b>				ADDRESS (Street, city, town, state) <b>Camden Ave. Salisbury, Maryland</b>			
DATE SIGNED <b>June 24/57</b>							
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Jun. 24, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>DATE JUN 25 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

UN 25 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

069143

Reg. Dist. No.

6934

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allen (Rural)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico River</b>				d. STREET ADDRESS <b>Eden R.D. # 2</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A</b> Last <b>SMALL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 29, 1876</b>	
9. AGE (in years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles W. Small</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Alsep</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Willard Morris (Daughter)</b> Address <b>R.D. #2 Eden, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>accidental Drowning</b> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>June 18 1957</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) <b>near Eden</b> (County) <b>Wicomico</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Kendrick McCullough</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Kendrick McCullough</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>June 19 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>		22d. LOCATION (City, town, or county) <b>Allen, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD:</b>				24. RECD BY REGISTRAR <b>JUN 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 21 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06915

6935

## CERTIFICATE OF DEATH

Reg. Dist. No. ...

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>MARYLAND</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>R.D.# 1</b>				STREET ADDRESS (If rural give location) <b>R.D.# 1</b>			
3. NAME OF DECEASED (First) (Middle) (Last) <b>MARY VIRGINIA SMITH</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>June 8 th 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>August 17, 1879</b>	9. AGE last birthday <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>21</b>		IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Siloam, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Isaac J. Murray</b>				14. MOTHER'S MAIDEN NAME <b>Jane Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mr. Wilmer J. Smith (Son) Sharptown, Maryland</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Cardiac insufficiency</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arterio-sclerosis</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>57</u> , to <u>6-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>57</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <b>Dr. William Smith</b>				ADDRESS (Street, city, town, state) <b>M.D. Medical Center - Salisbury, Md.</b>			
DATE SIGNED <b>June 10 1957</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 11, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Fruitland Cemetery</b>		LOCATION (City, town, or county) (State) <b>Fruitland, Maryland</b>	
24. REC'D BY REGISTRAR <b>JUN 12 1957</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

RECEIVED  
JUN 12 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06918

6913

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE</u>	
c. LENGTH OF STAY IN 1b <u>1 DAY</u>		d. STREET ADDRESS <u>904 MARKET ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LORENZO T. SOMEARS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 11 19 57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ISSAC SOMERS</u>		14. MOTHER'S MAIDEN NAME <u>DELIAH FRANCES HUGHES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. E. LESTER KIRBY, POCOMOKE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Circulatory Stenosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>14 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/11</u> , 19 <u>57</u> , to <u>6/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>57</u> , and that death occurred at <u>4:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>3215 D.W. St.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>		DATE SIGNED <u>6/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 14 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SALEM M.E. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		ADDRESS <u>POCOMOKE, MD.</u>	
24a. RECEIVED BY REGISTRAR <u>JUN</u>		24b. REGISTRAR'S SIGNATURE <u>John P. Hargrave</u>	

RECEIVED

JUN 17 1957

BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6914

## CERTIFICATE OF DEATH

06918

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. STREET ADDRESS <b>Port Deposit</b>			
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>Taylor</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/1893</b>	9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			11. BIRTHPLACE (State or foreign country) <b>Dayton, Ohio</b>	
13. FATHER'S NAME <b>James Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Amanda ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>212-18-6785</b>		17. INFORMANT <b>1064 Address Hospital Records &amp; Mrs. Gladys Binetta</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>19 57</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>May 13</b> , 19 <b>57</b> , to <b>June 30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>57</b> , and that death occurred at <b>2:25 P</b> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>V. Juerman</b>			ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>			DATE SIGNED <b>6/30/57</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>			Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>(Port Deposit (Cecil Co.) Maryland)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE A. PATTERSON &amp; SON</b>				ADDRESS <b>PERRYVILLE, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>7/3/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>			

U.S. BUREAU OF

3 1957

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this filing, the funeral director has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06919

6915

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>P.N. Gen. Hospital (D.O.A.)</b>		STREET ADDRESS <b>R.D.# 1</b>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>WALTER</b> (Middle) <b>JACOB</b> (Last) <b>TILGHMAN</b>				(Month) <b>JUNE</b> (Day) <b>21st</b> (Year) <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 18, 1899</b>	9. AGE last birthday <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>11</b>	Hours <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Used Cars</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Norman C. Tilghman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Pollitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Unk</b>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. Sara B. Tilghman (Wife) R.D.# 1 Salisbury, Maryland</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
X IMMEDIATE CAUSE (A) <b>Acute Cardiac Decompensation</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Rheumatic Heart Disease</b>				<b>years</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 20, 1957</b> , to <b>June 21, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Dr. William D. Gray</b>				ADDRESS (Street, city, town, state) <b>334 Camden Ave. Salisbury, Md</b> DATE <b>June 22, 1957</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Jun. 23, 1957</b>		NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. REC'D BY REGISTRAR <b>JUN 25 1957</b>		REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>			

BUREAU V. S.

JUN 15 1957

RECEIVED

6916

## CERTIFICATE OF DEATH

Reg. Dist. No.

922

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				d. STREET ADDRESS <b>R.D. # 1 (Shad Point)</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>FULTON</b> Last <b>TOWNSEND</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1911</b>	9. AGE (In years last birthday) yrs <b>46</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTH-PLACE (State or foreign country) <b>Shad Point Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William J. Townsend</b>				14. MOTHER'S MAIDEN NAME <b>Sara Jane Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Louise Townsend (Wife) R.D. # 1 (Shad Point) Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 15, 1957</b> to <b>June 13, 1957</b> , that I last saw the deceased alive on <b>June 13, 1957</b> , and that death occurred at <b>12:07 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rufus S. Gardner, Jr.</b>				ADDRESS (Street, city or town, state) <b>3215 Div. St., Salisbury, Md.</b>			
PHYSICIAN'S NAME (Type) <b>RUFUS S. GARDNER, JR.</b>				DATE SIGNED <b>June 13/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D. # 1 Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24. REGD. BY REGISTRAR <b>JUN 17 1957</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 17 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6917

## CERTIFICATE OF DEATH

06921

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>A 7th St</u>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>Julia</u> Last <u>Julia</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasoid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-71</u>		9. AGE (In years last birthday) <u>86</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Cameron</u>				14. MOTHER'S MAIDEN NAME <u>Lorraine Halloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lorraine Halloway</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Unk.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u> <u>Unk.</u> <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28, 1957</u> , to <u>June 2, 1957</u> , that I last saw the deceased alive on <u>June 1, 1957</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Semple</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>6/3/57</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Semple</u>				ADDRESS <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Backus St. Cret</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUNE 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Halloway</u>	

BUREAU V. S.

JUN 6 1957

RECEIVED



6936

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Wicomico</b>		STATE <b>Maryland</b>		COUNTY <b>Wicomico</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Salisbury</b>		<b>35 yrs</b>		TOWN <b>Salisbury</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RFD # 2</b>				STREET ADDRESS (if rural give location) <b>RFD # 2</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Norman</b> (Middle) <b>Edward</b> (Last) <b>Twilley</b>				(Month) <b>June</b> (Day) <b>12</b> (Year) <b>1957</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<b>Male</b>	<b>White</b>	<b>Widowed</b>	<b>4-29-1888</b>	<b>69</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Farmer</b>		<b>Farm</b>		<b>Allen, Maryland</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>William Fred Twilley</b>				<b>Nannie Dishmon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>220-32-8504</b>		<b>Edward Twilley, Salisbury, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
18b. IMMEDIATE CAUSE (A) <b>Cancer</b>						<b>24.6.1957</b>	
18c. ANTECEDENT CAUSE(S) DUE TO							
18d. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
18e. STATING UNDERLYING CAUSE LAST							
18f. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OR OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>1955</b>		<b>Carcinoma of colon</b>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 12, 1957</b> to <b>June 17, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> and that death occurred at <b>11:00</b> M, from the causes and on the date stated above.							
SIGNATURE <b>J. H. Lynd</b>				ADDRESS (Street, city, town, state)		DATE SIGNED <b>6-13-57</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<b>Burial</b>		<b>6-14-57</b>		<b>Hastings</b>		<b>Delmar, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<b>W. S. Hamel</b>		<b>W. S. Hamel Co Delmar, Del</b>			
DATE <b>8 1957</b>							

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JUN 18 1957

BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6918

Item 9 eliminated 6-14-57 at

06923

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>XO not known</u>			
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Wade</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 35-40</u> yrs.	9. AGE (in years last birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>in town</u>				14. MOTHER'S MAIDEN NAME <u>in town</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural and Subarachnoid Hemorrhage</u> <u>904.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <u>Fracture of Skull</u> DUE TO c) <u>1 day</u>							INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>scuffle in tavern, details not obtained.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>3:10</u> <u>pm</u> <u>May 31, 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>tavern</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick Mc Cullough</u>				DATE SIGNED <u>June 1, 1957</u>			
EXAMINER'S NAME (Type) <u>Kendrick Mc Cullough M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 17, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury</u> <u>Wicomico</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>K. C. Mc Cullough</u>				24a. REC'D BY REGISTRAR <u>JUN 17 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Mc Cullough</u>			

BUREAU V. S.

JUN 17 1957

RECEIVED

6919

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>304 Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>CANTWELL</b> Last <b>WALLER</b>				4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/1875</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Noah Cantwell</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Cantwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>215-26-5282</b>		17. INFORMANT Address <b>Mr. Wallace Waller, Forrest Hgts. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/4</b> , 19 <b>57</b> , to <b>6/4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/4/57</b> , 19 <b>57</b> , and that death occurred at <b>9:45 p.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Fred R. Gramse</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Md</b> DATE SIGNED <b>6/4/57</b>			
PHYSICIAN'S NAME (Type) <b>Fred R. Gramse</b>				S. Division St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REBURY <b>BOYD</b>		22b. DATE THEREOF <b>6/6/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>6-6-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloman</b>	

Normant Baker

RECEIVED

JUN 10 1957

BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06925  
337  
Reg. Dist. No.

6920

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>South Salisbury Blvd. U.S. Route # 13</b>				d. STREET ADDRESS <b>Spring Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SERMON</b> Middle <b>LINWOOD</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 20, 1910</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman—Bread Co. (Frehofer's)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sussex County Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Charlie Linwood White</b>				14. MOTHER'S MAIDEN NAME <b>Annie V. Kenny</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.# 214-10-7817</b>		17. INFORMANT <b>Mrs. Katherine B. White (Wife) Spring Hill Rd. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed Chest</b> (c) <b>Crushed Chest</b> DUE TO cause lost. (c) <b>Crushed Chest</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Crushed Chest</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Trunk struck pole &amp; turned over on him.</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:15 p.m. 6-11-57</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		22b. DATE THEREOF <b>Jun. 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Hebron, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>JUN 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Thos. J. Holloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

11 10 1967

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06926

Reg. Dist. No.

6921

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>735 Newton St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>F.</u> Last <u>WILKINS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1884</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Josephus ELLIOTT</u>		14. MOTHER'S MAIDEN NAME <u>ADDIE T. ELLIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. H. E. PARSONS</u>		Address <u>SALIS, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> "
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19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>No 1</u> , 19 <u>57</u> , to <u>June 13, 1957</u> , that I last saw the deceased alive on <u>June 13, 1957</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.		DATE SIGNED <u>June 15, 1957</u>
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.		ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>SALISBURY, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Williams</u>		24a. REC'D BY REGISTRAR <u>JUN 18 1957</u>	
ADDRESS <u>SALISBURY, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary T. Callender</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MARDELA</u>		LENGTH OF STAY (In this place) <u>2 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SHARPTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANZIE WINDSOR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6-20-1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-6-1868</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. J. KNOWLES</u>				14. MOTHER'S MAIDEN NAME <u>PRISCILLA VINCENT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>LUCKY GRAVENOR-SHARPTOWN</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
290.0 IMMEDIATE CAUSE (A) <u>Pernicious Anemia</u>						<u>1 year.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 20, 1957</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>1120P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Kuhlman</u> M. D.				ADDRESS (Street, city, town, state) <u>Sharptown Md</u>		DATE SIGNED <u>6/22/57</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5-23-57</u>		NAME OF CEMETERY OR CREMATORY <u>ST MARKS</u>		LOCATION (City, town, or county) <u>LAUREL DEL</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 25 1957</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Spauld</u>		ADDRESS <u>Sharptown Md</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

PLACE HERE THE NAME OF THE DECEASED

BUREAU V. S.

JUN 25 1957

RECEIVED

RECEIVED